

		FOR OFF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0000661</u> Facility Name: <u>FORD COUNTY NURSING HOME</u> Address: <u>RR2 1240 N MARKET STREET</u> <u>PAXTON</u> <u>60957</u> <div style="text-align: center;">Number City Zip Code</div> County: <u>FORD</u> Telephone Number: <u>(217)379-4896</u> Fax # () IDPA ID Number: <u>376000821</u> Date of Initial License for Current Owners: <u>1946</u> Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input checked="" type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input checked="" type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/01/99</u> to <u>11/30/00</u> and certify to the best of my knowledge and belief that the said content are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Title) <u>Administrator</u></td> </tr> <tr> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>CRAIG L. ATER</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Heritage Enterprises</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(309)823-7135</u> Fax # ()</td> </tr> </table> <p align="right"> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>		Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) _____	Paid Preparer	(Title) <u>Administrator</u>	(Signed) _____ (Date) _____	(Print Name and Title) <u>CRAIG L. ATER</u>	(Firm Name & Address) <u>Heritage Enterprises</u>		(Telephone) <u>(309)823-7135</u> Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL																																			
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In the event there are further questions about this report, please contact: Name: <u>CRAIG L. ATER</u> Telephone Number: <u>(309)823-7135</u>																																					

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number FORD COUNTY NURSING HOME# 0000661 Report Period Beginning: 12/01/99 Ending: 11/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>69</u>	Skilled (SNF)	<u>69</u>	<u>25,185</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)		<u>0</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)		<u>0</u>	5
6		ICF/DD 16 or Less			6
7	<u>69</u>	TOTALS	<u>69</u>	<u>25,185</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,530</u>	<u>5,145</u>	<u>0</u>	<u>21,675</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,530</u>	<u>5,145</u>		<u>21,675</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 86.06%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 1946

J. Was the facility purchased or leased after January 1, 1978?

YES ☐

Date _____

NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒

If YES, enter number

of beds certified 0

and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 11/30/00Fiscal Year: 11/30/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

	G/L	RECAP	CENSUS	DIFF
PP	5145	5145		0
IPA	16530	16530		0
medicare	25254	0		25254
	46929	21675		
IPA BEDHOLDS	0			
PP BEDHOLDS	0			
PP CONVERS	0			

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN
THE APPLICABLE SECTION TO ZERO DECIMAL PLACES

STATE OF ILLINOIS

Page 3

Facility Name & ID Number FORD COUNTY NURSING HOME # 0000661 Report Period Beginning: 12/01/99 Ending: 11/30/00
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	212,678	18,022		230,700		230,700	0	230,700		1
2	Food Purchase		65,369		65,369		65,369	0	65,369		2
3	Housekeeping	74,881	8,943		83,824		83,824	0	83,824		3
4	Laundry	16,521	1,470		17,991		17,991	0	17,991		4
5	Heat and Other Utilities			63,223	63,223		63,223	0	63,223		5
6	Maintenance	33,633	24,584	15,030	73,247		73,247	0	73,247		6
7	Other (specify):*							0			7
8	TOTAL General Services	337,713	118,388	78,253	534,354		534,354		534,354		8
	B. Health Care and Programs										
9	Medical Director			1,950	1,950		1,950	0	1,950		9
10	Nursing and Medical Records	744,057	62,090	154,034	960,181		960,181	0	960,181		10
10a	Therapy		104	144	248	(144)	104	0	104		10a
11	Activities	40,277	1,145	109	41,531		41,531	0	41,531		11
12	Social Services	20,426	0	5,700	26,126		26,126	0	26,126		12
13	Nurse Aide Training	0	1,000		1,000		1,000	0	1,000		13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Programs	804,760	64,339	161,937	1,031,036	(144)	1,030,892		1,030,892		16
	C. General Administration										
17	Administrative	49,173			49,173		49,173	0	49,173		17
18	Directors Fees							0			18
19	Professional Services			119,589	119,589		119,589	0	119,589		19
20	Dues, Fees, Subscriptions & Promotions			54,154	54,154	(37,778)	16,376	(4,436)	11,940		20
21	Clerical & General Office Expenses	34,211	8,739	8,403	51,353		51,353	0	51,353		21
22	Employee Benefits & Payroll Taxes			127,192	127,192		127,192	216,995	344,187		22
23	Inservice Training & Education			360	360		360	0	360		23
24	Travel and Seminar			6,009	6,009		6,009	(4,010)	1,999		24
25	Other Admin. Staff Transportation							0			25
26	Insurance-Prop.Liab.Malpractice			240	240		240	0	240		26
27	Other (specify):*			47,887	47,887		47,887	(47,071)	816		27
28	TOTAL General Administration	83,384	8,739	363,834	455,957	(37,778)	418,179	161,478	579,657		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,225,857	191,466	604,024	2,021,347	(37,922)	1,983,425	161,478	2,144,903		29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN
THE APPLICABLE SECTION TO ZERO DECIMAL PLACES

STATE OF ILLINOIS

Page 4

Facility Name & ID Number FORD COUNTY NURSING HOME # 0000661 Report Period Beginning: 12/01/99 Ending: 11/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			18,000	18,000		18,000	0	18,000			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			(1,593)	(1,593)		(1,593)	1,593				32
33	Real Estate Taxes			0				0				33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles			411	411		411	(368)	43			35
36	Other (specify):*							0				36
37	TOTAL Ownership			16,818	16,818		16,818	1,225	18,043			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					144	144	0	144			39
40	Barber and Beauty Shops	0	428	0	428		428	0	428			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee					37,778	37,778	0	37,778			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		428		428	37,922	38,350		38,350			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,225,857	191,894	620,842	2,038,593	0	2,038,593	162,703	2,201,296			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS
 Facility Name & ID Number **FORD COUNTY NURSING HOME** # **0000661** Report Period Beginning: **12/01/99** Ending: **11/30/00**
 VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY
1	Day Care	\$		\$
2	Other Care for Outpatients			
3	Governmental Sponsored Special Programs			
4	Non-Patient Meals			
5	Telephone, TV & Radio in Resident Rooms	(368)	35	
6	Rented Facility Space	0	34	
7	Sale of Supplies to Non-Patients			
8	Laundry for Non-Patients			
9	Non-Straightline Depreciation	0	30	
10	Interest and Other Investment Income	1,593	32	
11	Discounts, Allowances, Rebates & Refunds			
12	Non-Working Officer's or Owner's Salary			
13	Sales Tax	0	2	
14	Non-Care Related Interest		32	
15	Non-Care Related Owner's Transactions			
16	Personal Expenses (Including Transportation)		24	
17	Non-Care Related Fees	0	20	
18	Fines and Penalties			
19	Entertainment	(4,010)	24	
20	Contributions	0	27	
21	Owner or Key-Man Insurance			
22	Special Legal Fees & Legal Retainers	0	19	
23	Malpractice Insurance for Individuals			
24	Bad Debt	(47,071)	27	
25	Fund Raising, Advertising and Promotional	(4,436)	20	
26	Income Taxes and Illinois Personal Property Replacement Tax			
27	Nurse Aide Training for Non-Employees			
28	Yellow Page Advertising			
29	Other-Attach Schedule			
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (54,292)		\$

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
33	Amortization of Organization & Pre-Operating Expense		33
34	Adjustments for Related Organization Costs (Schedule VII)	216,995	34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35) (sum of SUBTOTALS	\$ 216,995	36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 162,703	37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
 (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38			\$		38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47			\$		47

Print Preview

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Facility Name & ID Number **FORD COUNTY NURSING HOME** # **0000661** Report Period Beginning: **12/01/99** Ending: **11/30/00** Summary A

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary		Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
		A. General Services													
1	Dietary		0	0		0	0	0	0	0	0	0	0	0	1
2	Food Purchase		0	0		0	0	0	0	0	0	0	0	0	2
3	Housekeeping		0	0		0	0	0	0	0	0	0	0	0	3
4	Laundry		0	0		0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities		0	0		0	0	0	0	0	0	0	0	0	5
6	Maintenance		0	0		0	0	0	0	0	0	0	0	0	6
7	Other (specify):*		0	0		0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services		0	0	0	0	0	0	0	0	0	0	0	0	8
		B. Health Care and Programs													
9	Medical Director		0	0		0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records		0	0		0	0	0	0	0	0	0	0	0	10
10a	Therapy		0	0		0	0	0	0	0	0	0	0	0	10a
11	Activities		0	0		0	0	0	0	0	0	0	0	0	11
12	Social Services		0	0		0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training		0	0		0	0	0	0	0	0	0	0	0	13
14	Program Transportation		0	0		0	0	0	0	0	0	0	0	0	14
15	Other (specify):*		0	0		0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs		0	0	0	0	0	0	0	0	0	0	0	0	16
		C. General Administration													
17	Administrative		0	0		0	0	0	0	0	0	0	0	0	17
18	Directors Fees		0	0		0	0	0	0	0	0	0	0	0	18
19	Professional Services		0	0		0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions		(4,436)	0		0	0	0	0	0	0	0	0	(4,436)	20
21	Clerical & General Office Expenses		0	0		0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes		0	216,995		0	0	0	0	0	0	0	0	216,995	22
23	Inservice Training & Education		0	0		0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar		(4,010)	0		0	0	0	0	0	0	0	0	(4,010)	24
25	Other Admin. Staff Transportation		0	0		0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice		0	0		0	0	0	0	0	0	0	0	0	26
27	Other (specify):*		(47,071)	0	0	0	0	0	0	0	0	0	0	(47,071)	27
28	TOTAL General Administration		(55,517)	216,995	0	0	0	0	0	0	0	0	0	161,478	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)		(55,517)	216,995	0	0	0	0	0	0	0	0	0	161,478	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **FORD COUNTY NURSING HOME**

0000661

Report Period Beginning:

12/01/99

Ending:

11/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0		0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0		0	0	0	0	0	0	0	0	31
32	Interest	1,593	0	0		0	0	0	0	0	0	0	1,593	32
33	Real Estate Taxes	0	0	0		0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0		0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(368)	0	0		0	0	0	0	0	0	0	(368)	35
36	Other (specify):*	0	0	0		0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,225	0	0	0	0	0	0	0	0	0	0	1,225	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(54,292)	216,995	0	0	0	0	0	0	0	0	0	162,703	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ *	

Sum_6A

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6B

Facility Name & ID Number FORD COUNTY NURSING HOME # 0000661 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$	0		\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name & ID Number FORD COUNTY NURSING HOME # 0000661 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number

FORD COUNTY NURSING HOME

#

0000661

Report Period Beginning:

12/01/99

Ending:

11/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

[Print Previe](#)

Facility Name & ID Number FORD COUNTY NURSING HOME

0000661

Report Period Beginning: 12/01/99

Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8

Show Pgs 8E thru 8

Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization

Heritage Enterprises

Street Address

115 W. Jefferson

City / State / Zip Code

Bloomington, IL 61701

Phone Number

(309) 823-7135

Fax Number

(309) 829-5477

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Print Preview

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10												(1,593)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

	\$	0	1
1. Real Estate Tax accrual used on 1999 report.	\$	0	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	0	2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	0	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

	FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

X. BUILDING AND GENERAL INFORMATION:A. Square Feet: 33,800 B. General Construction Type: Exterior Brick/Wood Frame _____ Number of Stories _____C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground! (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO
If so, please complete the following:1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

[Print Preview](#)

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

Page 12

Facility Name & ID Number FORD COUNTY NURSING HOME

0000661

Report Period Beginning:

12/01/99

Ending:

11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	69				\$ 757,502	\$		\$	\$	\$	4
5					650						5
6					955,030						6
7											7
8											8
	Improvement Type**										
9	1983			1983	38,920						9
10	1985			1985	64,800						10
11	1986			1986	8,070						11
12	1987			1987	3,788						12
13	1988			1988	10,194						13
14	1989			1989	2,554						14
15	1990			1990	506						15
16	1991			1991	6,998						16
17	1992			1992	8,653						17
18	1993			1993	4,860						18
19	1995			1995	1,829						19
20	Overhead Lighting			1996	5,392						20
21	Overhead Lighting--Resident Rooms			1996	9,941						21
22	A/C Equipment			1996	1,880						22
23	Dietary A/C Equipment			1997	10,339						23
24	Nurses Station A/C Equipment			1998	1,685						24
25	Roof Replacement			1998	10,350						25
26	Drapes			1998	24,467						26
27	Gutters			1998	5,005						27
28	Wall Heater			1998	3,091						28
29	A/C Unit			1998	5,875						29
30	Kitchen Drain			1999	11,070						30
31	Water Conditioner			1999	1,672						31
32	Door Alarm			1999	2,917						32
33											33
34											34
35	Book Depreciation					18,000		18,000		272,804	35
36	TOTAL (lines 4 thru 35)				\$ 1958038	\$ 18,000		\$ 18,000	\$	\$ 272,804	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

0000661

Report Period Beginning:

12/01/99

Ending:

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Facility Name & ID Number FORD COUNTY NURSING HOME

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Window Replacements			2000	2,344						9
10	Windows			2000	5,607						10
11	Roof Top A/C Unit			2000	8,796						11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 16,747	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

0000661

Report Period Beginning:

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Page 12B

11/30/00

Facility Name & ID Number FORD COUNTY NURSING HOME

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

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Report Period Beginning:

12/01/99

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Page 12C

11/30/00

Facility Name & ID Number FORD COUNTY NURSING HOME

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1		2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$		4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2

**Improvement type must be detailed in order for the cost report to be considered complete

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

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Report Period Beginning:

12/01/99

Ending:

Page 12D

11/30/00

Facility Name & ID Number FORD COUNTY NURSING HOME

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number **FORD COUNTY NURSING HOME**# **0000661**

Report Period Beginning:

12/01/99

Ending:

11/30/00**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 133,863	\$	\$	\$		\$	37
38	Current Year Purchases	11,726						38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 145,589	\$	\$	\$		\$	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 2,120,374	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 18,000	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 18,000	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 272,804	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

[Print Preview](#)

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 43 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending

Annual Rent

12. _____ /2001 \$ _____

13. _____ /2002 \$ _____

14. _____ /2003 \$ _____

* If there is an option to buy the building,
please provide complete details on attached
schedule.** This amount plus any amortization of lease
expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number **FORD COUNTY NURSING HOME**

#

0000661

Report Period Beginning:

12/01/99

Ending:

11/30/00**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)****A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES
☐ NO2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

COMMUNITY COLLEGE

☐

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

HOURS PER AIDE

If "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.**B. EXPENSES****ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$		\$	\$
2	Books and Supplies		1,000		1,000
3	Classroom Wages (a)		0		
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		0		
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 1,000	\$	\$ 1,000
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,000		

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOMEIn the box below record the amount of income your
facility received training aides from other facilities.\$ **D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for
your own aides must agree with Sch. V, line 13, col. 8.(f) Attach a schedule of the facility names and addresses
of those facilities for which you trained aides.

Print Preview

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a/3	hrs	\$		\$ 0	\$		\$	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			0				2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			0				4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							
12	Exceptional Care Program									12
13	Other (specify): Lab	39/3				144			144	13
14	TOTAL			\$		\$ 144	\$		\$ 144	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Previe

pt adj 0
st adj 0
Ot adj 0

drugs 0

Facility Name & ID Number FORD COUNTY NURSING HOME

STATE OF ILLINOIS

0000661

Report Period Beginning: 12/01/99

Ending:

Page 17

11/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/00

(last day of reporting year)

This report must be completed even if financial statements are attached

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 97,287	\$	1
2	Cash-Patient Deposits	25,248		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	297,588		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,005		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	30,264		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 461,392	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	0		13
14	Buildings, at Historical Cost	55,346		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	371,281		16
17	Accumulated Depreciation (book methods)	(272,804)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify)			22
23	Other(specify):	0		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 153,823	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 615,215	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 91,301	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	189,998		30
31	Accrued Taxes Payable (excluding real estate taxes)	0		31
32	Accrued Real Estate Taxes(Sch.IX-B)	0		32
33	Accrued Interest Payable	0		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		6,315		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 287,614	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	0		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 287,614	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 327,601	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 615,215	\$	48

*(See instructions.)

Print Preview

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 503,187	1
2	Restatements (describe):		2
3	audit Adjustment	0	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 503,187	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(175,586)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (175,586)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 327,601	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1		2	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,927,613	1
2	Discounts and Allowances for all Levels	(64,652)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,862,961	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients		5
6	Therapy	0	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	(172)	12
13	Barber and Beauty Care	0	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	0	16
17	Sale of Drugs	0	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	218	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 46	23
	D. Non-Operating Revenue		
24	Contributions	0	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		0	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,863,007	30

1		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	\$ 534,354	31
32	Health Care	1,031,036	32
33	General Administration	455,957	33
	B. Capital Expense		
34	Ownership	16,818	34
	C. Ancillary Expense		
35	Special Cost Centers	428	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,038,593	40
41	Income before Income Taxes (line 30 minus line 40)**	(175,586)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (175,586)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Print Preview

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			\$ 41,584	\$	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses			162,816		3
4	Licensed Practical Nurses			147,662		4
5	Nurse Aides & Orderlies			391,995		5
6	Nurse Aide Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants			40,277		10
11	Social Service Workers			20,426		11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants			212,678		15
16	Dishwashers					16
17	Maintenance Workers			33,633		17
18	Housekeepers			74,881		18
19	Laundry			16,521		19
20	Administrator			49,173		20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical			34,211		24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	0	0	\$ 1,225,857 *	\$	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director		1,950		36
37	Medical Records Consultant		0		37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,950		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		5,700		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 9,600		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		\$ 16,430		50
51	Licensed Practical Nurses		5,933		51
52	Nurse Aides		128,109		52
53	TOTAL (lines 50 - 52)		\$ 150,472		53

Print Preview

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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XX. GENERAL INFORMATION:

0000661

Report Period Beginning:

12/01/99

Ending:

11/30/00

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? _____
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO xx If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 37,778
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 117,239
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? _____ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Bray, Drake, Guthrie and Richardson The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. Not complete as of the filing date.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees

[illegible]